of the consequential rises in the prices of staple items in the typical diet, increases in transport costs which inhibit the operation of local markets, and deliberate attempts by the regime to buy up stocks in areas under its control where there are marketable surpluses.[30] The incidence of malnutrition has been particularly marked in Badakhshan, where 50.1% of children in Faizabad, surveyed in Autumn 1983, showed a weight-for-height ratio more than two standard deviations below the mean.[31] These conditions have contributed to the outflow since 1983 of many refugees from this predominantly Tajik area, something which, as noted earlier, has altered the character of the refugee population in Pakistan. If regions such as Badakhshan move from prefamine to famine conditions, many residents will have no course open to them but to leave before it is too late. Thus, to prevent a flood which will swamp current facilities in Pakistan, private and especially public relief agencies might need to look at measures such as the distribution of cash[32] to those at risk of famine in Afghanistan to prevent them from falling victim to the crisis of entitlements which typically produces famine.[33]

Equally, Western governments might consider whether it would not be better to support those who are attempting to provide medical treatment to people inside Afghanistan, rather than wait for Afghans to arrive in Pakistan in search of it. A number of private organisations, such as the Union of Afghan Mujahid Doctors, the Swedish Committee for Afghanistan, and the French organisations Médicins sans Frontières, Médicins du Monde, and Aide Médicale Internationale, have worked tirelessly to bring medical treatment to those within Afghanistan who need it.[34] Over 400 volunteer doctors and nurses, mainly French, have undertaken this distressing task.[35] It is not without risks: a French physician, Dr Philippe Augoyard, has recently written a graphic description of his experiences on being captured by forces of the

regime.[36] Nonetheless, these medical workers are overwhelmingly welcomed by the Afghan people, who see them both as a source of immediate aid, and also a channel through which news of the plight of the Afghans can be spread in the wider world.[37]

To predict with certainty the future course of events in Afghanistan and Pakistan is an extraordinarily daunting task. However, health professionals must work, for planning purposes, on the strength of various implicit political and economic prognoses, and in making these prognoses a number of specific factors should be taken into account.

The most obvious is the course of the war and war-related conditions within Afghanistan. Increases in the general ferocity of the war - for example, through the introduction of new military technology by the forces of the Soviet Union - can be expected to produce an upsurge in the movement of refugees to Pakistan. Likewise, if the prices of animals in rural markets seem suddenly to drop, this will be a sure sign that staple items in the diet have become so expensive that it is necessary to sell one's animal stocks in order to obtain cash with which to buy food. A renewed population flow from the areas thus affected is likely to follow.

However, changes in Pakistan may also have implications for the conduct of refugee relief. The Pakistan People's Party, under the leadership of Benazir Bhutto, is committed to recognising the Karmal regime, suppressing the Mujahideen, and securing the repatriation of the Afghan refugees to Afghanistan. There is no doubt that the refugees would refuse to budge as long as there remained any trace of communist influence within the regime in Kabul. For this reason, the advent to power of the Pakistan People's Party would threaten to produce a violent clash between the Afghan refugees and the regime hosting them, of a

kind which has been entirely avoided so far. This would be most regrettable, for thus far the refugees have been accommodated with remarkably little resentment from local populations. The unwillingness of Afghans to return to Afghanistan as long as atheistic communists are in power is also a reason why the indirect Geneva negotiations, currently in progress, are most unlikely to result in a settlement of the Afghanistan situation unless the USSR decides to abandon its Afghan surrogates.

Successive Australian governments have provided diplomatic support for the people of Afghanistan, and have refused to accord recognition to the Karmal regime. Foreign Minister Hayden was bitterly attacked by the Karmal regime's newsagency following his visit to Pakistan in May 1985.[38] Australia has also supplied multilateral aid to support UNHCR and ICRC programmes for Afghan refugees in Pakistan. However, the volume of aid has fallen from a level of $6.363 million in 1983-84 to a proposed level of only $4.6 million in 1985-86[39], which in constant price terms is a substantial drop. There are also many specific projects in the field of refugee relief which merit direct Australian support. These projects have emerged in response to the immediate health needs of the refugees. It is these needs which are the concern of the second half of this paper.

The roughly three million Afghan refugees in Pakistan are accommodated in approximately 350 refugee camps in different parts of the country, most of them near the border with Afghanistan. Of these camps, 311 house registered refugees[40], and the remainder unregistered refugees. Approximately 75% of the refugees are located in the North West Frontier Province, 20% in Baluchistan, and 4% in the Punjab.[41] In addition, there are small groups of Afghan refugees who are not registered in the camps and live on a self-sufficient basis in cities such as Peshawar, Islamabad, and Karachi. Most of these refugees work in urban areas, and some of them have relatives in Western countries, and are waiting to leave Pakistan. There are also many Afghan refugees who are awaiting registration, and who are living in primitive transit camps for unregistered refugees, such as the Kachagarai, Ayatabad, and Bajawray camps. One problem which the Government of Pakistan has been striving to overcome is that of camp officials demanding 'under the table' fees for the registration of new arrivals.[42]

There are a number of significant health care problems which confront the refugees. Among the most important are the following.

*The lack of immediate registration in refugee camps: The long wait for new arrivals to be registered and to receive rations is a grave problem. Only when they are registered can refugees receive the all-important pass book, which they need to receive food, a tent, blankets, and the other entitlements of registered refugees. Even the luckiest refugees must as a rule wait between two and three months to be registered, and some people who arrived in Pakistan in 1983 are <u>still</u> waiting for registration. While 45,000 to 50,000 refugees are believed

to have arrived in Pakistan in 1985, according to the UNHCR only 20,000 have been registered by the Government.[43]

*The lack of regular distribution of food: The daily rations provided by UN agencies and the Government of Pakistan include: wheat, 500g; edible oil, 30g; and powdered milk, 30g (provided through the World Food Programme); and sugar, 20g; and tea, 3 g (provided through the UNHCR).[44] Unfortunately, there are occasional disruptions in food supply[45]. We observed that not all the rationed materials arrive at the one time. For example, some refugees receive wheat and oil regularly, but only rarely see items such as sugar, tea, and powdered milk. Unregistered refugees, of course, receive no official rations at all.

*A diet which lacks variety: typical refugee meals are tea with bread for breakfast in the early morning, cooked or fresh vegetables with oven bread, traditional 'nan' for lunch, and fried vegetables, and occasionally meat with bread, for dinner. Sometimes the staple food is simply nan supplemented by many cups of sweet tea.[46] Refugees formally receive a monthly allowance of 50 Pakistan rupees (approximately US$4), with a ceiling of 350 rupees (approximately US$28) per family, which can be spent on additional food. However, refugee ration books which we were able to see suggest that it is more usual for this allowance to arrive only once or twice a year.

*Shortages of appropriate food for nursing mothers: Amongst Afghan mothers, it is usual for breast feeding to continue for up to two years. However, very often this is halted by subsequent pregnancy, and weaning begins when the child is 8-9 months old. Some babies will be breast fed by a lady other than the mother, but the majority will commence a diet of diluted powdered milk, bread, rice, and sweet tea. These mothers do not have ready sources of protein in their diet. Most

can do no more than attempt to eat eggs, and such meat as may be available, for about 40 days after the birth. Yoghurt must be avoided because it inhibits lactation.

*The lack of clean water for the refugees: While the aim of the UNHCR is to provide 25 litres of fresh water per person per day, in many camps, people still use narrow rivers or canal water for drinking, washing and cooking. This water rapidly becomes contaminated with waste, and bacterial germs and parasites. Even animals use the water from these rivers and channels. Some refugee camps have cement water tanks built by the UN and the Government of Pakistan, which provide potable water, but often they are inadequately maintained. Some shallow wells have been built by bodies such as the Austrian Relief Committee and the Union of Afghan Mujahid Doctors. However, these wells are open at the surface, which exposes their contents to the risk of contamination. Water is also supplied through a limited number of deep wells built with assistance from UNICEF. Much of the refugees' water needs much still be met either from tankers, or from perennial springs. Many refugees must carry water to their tents in an earthenware container called a 'koza'[47]

*Some refugees experience a serious lack of appropriate shelter. We have seen some camps where there are not even tents for all who need them, and refugees must construct a covering from sheets of plastic. Replacement tents are hard to find, and in some camps refugees have had to use the one tent for up to five years, by which time it has become unfit for use. Some refugees have constructed traditional mud houses, but from the point of view of health they are even less appropriate, and very often have only one opening, a door for entry.

*The hot and humid climate in Pakistan: Most Afghan refugees come from cold parts of Afghanistan, and find it very difficult to adapt to these conditions. The climate in Pakistan produces infection among Afghan refugees, and permits the rapid transmission of communicable diseases in refugee camps. The Kirghiz of Afghanistan, who were forced by the Soviet invasion to leave their lands in the Pamir mountain range, suffered acutely from the heat when they arrived in Pakistan, and 150 died. Happily, the Government of Turkey resettled them in mountains in central Turkey, where they have been able to resume their lifestyle. About 4000 people were helped in this way, far more than the Australian Government has been prepared to admit to this country.[48]

*Crowded conditions: The gathering of many people together in small huts and settlements produces problems of hygiene. A number of practices in the camps are extremely unhygienic, particularly the location of latrines near tents and mud houses, and the combination of solid waste with water. Solid waste is never shifted, and when the latrines are full, their contents will frequently flow out towards tents or mud houses. Drainage ditches are often polluted by sewage. Furthermore, animals live in the camps, and dry animal waste is burned as a fuel. The dumping of rubbish and refuse near dwellings also aids the spread of infectious diseases. In addition, in some camps there is no mechanism for the disposal of storm water, and thus when it rains heavily, water collects inside the camp, damaging both the premises, and the health of refugees. This was particular noticeable at the Khorasan refugee camp. As a result of all these factors, the problems of sanitation in the camps are tremendous. The UNHCR[49] and the Austrian Relief Committee[50] among others have established and supervised sanitation projects for the refugee camps, but their impact as yet has been limited.

*The location of families in one tent or mud house: Congestion is a serious problem. The average size of a family in one tent or mud house is 6.2-6.5[51], but our observations suggest that because of the arrival of other family members, the number of people within a tent may often be well above this figure, and is frequently greater than 10.

All these factors have contributed to a serious health care situation, to which a number of indicators point. First, the infant mortality rate is high, and recent figures suggest that for every 1000 Afghan children born in the refugee camps, 156 die in the first year of life, and 225 die before reaching the age of five. From every 100,000 live births, 1176 mothers die.[52] Second, seasonal diseases, diarrhoea, tuberculosis, malaria, measles, tetanus, whooping cough, impetigo, parasitical diseases, respiratory infections, trachoma, and fungus infections are all found within the refugee population.

Tuberculosis is the most serious long-term communicable disease among Afghan refugees. Tuberculine surveys have revealed that a high proportion of Afghan children are infected, between 25% and 33% as opposed to 13% among local Pakistani children.[53] Cramped conditions encourage the rapid transmission of the disease. However,the Program Coordinator of Italian Cooperation for Development informed us that only 1.9% of the total refugee population in the North West Frontier Province are suffering from active pulmonary tuberculosis. The diagnosis and treatment of tuberculosis is difficult because of a severe shortage of X-ray machines, and sophisticated diagnostic equipment.

The prevalence of malaria is also high, and an August 1984 survey in five camps showed a 5.5% incidence of plasmodium vivax and plasmodium falciparum.[54] However, the Austrian Relief Committee Anti-Malaria Programme revealed a 21% incidence in Baghicha Camp, which

points to considerable problems in particular areas.[55] The incidence of malaria is particularly high in summer. Various organisations have undertaken anti-malaria programmes, but it remains a significant cause of death among Afghan refugees.

Measles has an incidence of around 13%, and the incidence remains high, because immunisation is expensive.[56] When 125 infant deaths between May 1983 and April 1984 were analysed in a systematic survey, it was found that in the 62% of cases where the mother had reported a cause of death, measles preceded death in nearly a quarter of the cases. Neonatal tetanus in the same period may have contributed to at least 14% of childhood deaths.[57]

This survey showed diarrhoeal diseases to be perhaps of gravest concern. Almost 64% of child deaths were preceded by diarrhoea. The Union of Afghan Mujahid Doctors has noted a high prevalence of diarrhoeal diseases - 30% to 50% - amongst Afghan children. Such diseases made up 12.5% of the Basic Health Unit caseload in the North West Frontier Province in 1984.[58] Poor sanitation and personal hygiene are directly associated with diarrhoeal diseases. The high rate of mortality from such diseases is particularly sad, as they are easily treatable with oral rehydration solution. The Austrian Relief Committee's Sanitation and Basic Health Programme permitted in 1984 the construction of 18,045 latrines, and the distribution of 45, 631 cakes of soap. Nonetheless, this amounts only to one cake of soap for every 66 people.

Among other diseases, typhus has been detected in the colder parts of the North West Frontier Province where clothes are worn for prolonged periods and washing is difficult, but at least has proved amenable to prevention by vaccination. Trachoma has an incidence of 40%

in some camps, and the Union of Afghan Mujahid Doctors is making particular efforts to train medical assistants to treat it. Skin diseases are also very common.

Malnutrition is also a problem, but as a rule does not cause death. It tends to be found amongst the poorest and most underprivileged families, and amongst new arrivals who have suffered from lack of food during their flight. Diseases such as anaemia, diarrhoea, hypoglycaemia, hypothermia, intestinal infection, potassium deficiency, tuberculosis, measles, skin infections, and Vitamin A deficiency are all associated with nutritional problems.

Afghan women in the refugee camps, especially those who are pregnant, face particular problems. Cultural reasons prevent them from receiving treatment from male doctors, and only in emergency cases can they call for a female physician. Many deaths are not reported, because families fear a reduction of their food rations. Childbirth tends to be carried out under the supervision of traditional midwives with little grasp of sanitation, and with the mother in a standing or sitting position. The umbilical cord will be severed with a sharp stone or ordinary knife, and very often the cord becomes infected. Furthermore, families of more than seven children are very common among Afghans, and many women suffer from gynaecological problems, which are compounded by problems of malnutrition, and psychological problems caused by grief at the loss of homes and family members. It is difficult to dissuade women from bearing children, as very often a new child is the only available source of joy for the refugee. Furthermore, many fear that if they do not continue to bear children, their husbands will seek a second, more fertile wife.

Given the restrictions imposed by purdah, a number of organisations, including Austcare, have sought to train Lady Health

If one were to ask which country of the world has been most ravaged by political turbulence in the last decade, one would be hard pressed to find a better example than Afghanistan. Since December 1979, it has been wracked by a conflict of horrific ferocity between on the one hand the armed forces of the Soviet Union and their puppets, and on the other hand the Afghan Islamic resistance. These courageous resistance fighters - known as the Mujahideen - are endeavouring to rid their country of the invaders and establish a regime under which the people of Afghanistan will be free to practice their religion, and live in a society unmarred by 'continual fear, and danger of violent death'[1], two of the terrible attributes of a state of war which were set out over three hundred years ago by Thomas Hobbes.

For those concerned with health care, one of the greatest problems which has resulted from the war in Afghanistan has been a quite massive haemorrhaging of its population into the neighbouring states of Iran and Pakistan. Pakistan currently houses a population of over 3 million Afghan refugees[2], which constitutes the largest single concentration of refugees anywhere in the world. Coping with an influx of this sort is a major public health undertaking, and one which can fruitfully be studied by health professionals concerned to learn from the experiences of those who have been directly involved in mounting a relief operation of such unprecedented magnitude.

However, any appraisal of past performance, and anticipation of future requirements in the sphere of refugee relief and health care will depend upon non-medical as well as purely medical considerations. Non-medical factors are usually responsible for the emergence of any refugee problem, a fact which is implicit in the very definition of a refugee.[3] Likewise, non-medical factors determine the social character

Visitors as a way of coping with the special difficulties confronting women refugees. The dispensaries run by women health personnel provide an escape for the refugees, a place where they can gather and talk with each other. Female health visitors and midwives are also attached to Basic Health Units, adminstered by the UNHCR and staffed as well by a medical officer, a sanitary inspector, a dispenser, and a nursing orderly. However, in 1983, there were only 129 such units for all the refugees, and thus a very limited number of staff concerned specifically with the problems of the huge number of women refugees. (There are no hospitals in the refugee camps, and refugees in need of hospitalisation must be accommodated in either Pakistani hospitals, or hospitals privately run by organisations such as the International Committee of the Red Cross, the Saudi Red Crescent, the Kuwait Red Crescent, the Pakistan Red Crescent, and Afghan bodies. These are located in urban areas, and there are problems in moving patients to them. There are only 80 hospital beds for women in the hospitals specially established for Afghan refugees in the North West Frontier Province.[59])

Problems of health are intimately related to levels of education within the society under study. A very large proportion of the refugee children, by one estimate approximately 50%, are of school age.[60] The rate of literacy in Afghanistan in 1975 was estimated at 12%.[61] However, the literacy level in rural Afghanistan is markedly less than this: 7% for men and only 2% for women.[62] In 1984, there were 420 primary schools for the refugees, with 1017 Afghan teachers, 397 Pakistani teachers, and 55,904 pupils, of whom 51,104 were male, and 4,800 female. However, 84% of male refugees of school age, and 98.5% of female refugees of school age, were not receiving education.[63] (Some boys are able to study in the madrassa, or Mosque school, but the curriculum covers only religious subjects.) There is on average one

primary school per refugee village, established under a tarpaulin, and stocked with equipment provided by the Government of Pakistan, the UN, and voluntary agencies. This equipment rarely extends to furniture, and is usually limited to a blackboard and chalk. However, there are no high schools for the refugees, which means that the education which they receive tends to be in traditional basic skills such as literacy.

This limits the supply of Afghan refugees who can fruitfully be trained to provide primary health care. Nonetheless, various organisations have embarked on programmes designed to train Afghans as health workers. For example, the Union of Afghan Mujahid Doctors offers three courses, a two year training course for doctors' assistants, a one year training course for health assistants, and a three to six month course for primary health workers. The International Committee of the Red Cross offers training courses, as do Aide Médicale Internationale[64], Union Aid for Afghan Refugees, Freedom Medicine, the Kuwait Red Crescent, the International Medical Corps, the Austrian Relief Committee, and Medical Training for Afghans. These courses have covered, among other topics, tuberculosis, malaria, and diarrhoeal disease control, nutrition, sanitation, diagnostic microscopy, and vaccination.[65] A number of these organisations are working with very meagre resources and equipment. Their need for them is acute, as is their need for up-to-date curriculum materials.

In conclusion, one can only hope that the Australian Government will recognise the importance of providing practical and direct assistance to those Afghan refugees who have fled to Pakistan. What is often overlooked is that these people have already suffered immensely even before their arrival in Pakistan. We should never forget that our ability to respond to their sufferings with practical help is a measure not of their worth as human beings, but of our own.

FOOTNOTES

[1]Thomas Hobbes, Leviathan (Paperback ed., Collins, London, 1962) p.151.

[2]Figures issued in 1985 to update the publication Humanitarian Assistance Programme for Afghan Refugees in Pakistan (1st ed., Chief Commisionerate for Afghan Refugees, Government of Pakistan, Islamabad, July 1984) state that on 31.10.1985, Pakistan was housing 2,671,790 registered Afghan refugees, as well as an estimated 400,000 unregistered refugees. Other sources suggest that the number of unregistered refugees has been even higher. For example, Stephanie Simmonds, Patrick Vaughan and S. William Gunn, Refugee community health care (1st ed., Oxford University Press, New York, 1983) p.4 imply that in mid-1982, 800,000 Afghan refugees in Pakistan were not receiving national and international assistance.

[3]On the meaning of 'refugee', see for example B. Martin Tsamenyi, 'The "Boat People": Are They Refugees?', Human Rights Quarterly, vol.5, no.3, 1983, pp.348-373, Andrew E. Shacknove, 'Who is a Refugee?' Ethics, vol.95, no.2, January 1985, pp.274-284, and Patricia Hyndman, 'Refugees under International Law with a Reference to the Concept of Asylum', The Australian Law Journal, vol.60, no.3, March 1986, pp.148-155.

[4]A number of excellent books have been written surveying recent Afghan political history. Of particular merit are the following: Anthony Arnold, Afghanistan: The Soviet Invasion in Perspective (2nd ed., Hoover Institution Press, Stanford, 1985), Michael Barry, Le Royaume de

L'Insolence (1st ed., Flammarion, Paris, 1985), Henry S. Bradsher, Afghanistan and the Soviet Union (2nd ed., Duke University Press, Durham, 1985), Thomas T. Hammond, Red Flag Over Afghanistan (1st ed., Westview Press, Boulder, 1984), and Olivier Roy, L'Afghanistan: Islam et modernité politique (1st ed., Éditions du Seuil, Paris, 1985).

[5]See Roy, op.cit., pp.115-123.

[6]Robert L. Canfield, 'Western Stakes in the Afghanistan War', Central Asian Survey, vol.4, no.1, 1985, pp.121-135 at p.128.

[7]See Edward Girardet, Afghanistan: The Soviet War (1st ed., Croom Helm, London, 1985) pp.107-110.

[8]Annick Billard, 'The widows' village of Kerala', Refugees, no.18, June 1985.

[9]Cited in Michael Barry, 'Afghanistan - Another Cambodia?' Commentary, vol.74, no.2, August 1982, pp.29-37, at p.30. This type of atrocity continues to be practised. On October 20 1984, twelve men and four women were drenched with kerosene and set ablaze by Soviet soldiers. See Bernard Dupaigne (ed.), Les Droits de l'homme en Afghanistan (1st ed., AFRANE, Paris, October 1985) p.20.

[10]'La mort de Nur Mohammed Taraki', Les Nouvelles d'Afghanistan, no.22, March-April 1985, pp.11-12.

[11]This point is argued at greater length in William Maley, 'Prospects for Afghanistan', Australian Outlook, vol.39, no.3, December 1985, pp.157-164, at p.159.

[12]Dietrich Wiebe, 'Die Flüchtlingslager', in Paul Bucherer-Dietschi and Christoph Jentsch (eds.), Afghanistan (1st ed., Stiftung Bibliotheca Afghanica, Liestal, 1986) pp.327-340 at p.327.

[13]The Canberra Times, 16 January 1985.

[14]For a more detailed discussion of some of these cleavages, see Tradition and dynamism among Afghan refugees (1st ed., ILO and UNHCR, Geneva, 1983) pp.17-29. On the complexity of Islam in Afghanistan, see Louis Dupree, Afghanistan (Paperback ed., Princeton University Press, Princeton, 1980) Chapter 8.

[15]'Mieux aider, mieux connaître', Défis Afghans, no.7, February-April 1986, pp.20-23, at pp.20-21.

[16]The New York Times, October 26, 1980, p.8. We wish to thank Mary Louise Hickey for supplying us with this reference.

[17]Lee O. Coldren, 'Afghanistan in 1985: The Sixth Year of the Russo-Afghan War', Asian Survey, vol.26, no.2, February 1986, pp.235-245 at p.235.

[18]Edward Girardet, 'The largest of all refugee operations', Refugees, no.26, February 1986, pp.10-11, at p.10.

[19]See footnote 2.

[20]Mary Louise Hickey, 'Afghan Refugees in Pakistan', Current Affairs Bulletin, vol.62, no.5, October 1985, pp.20-24. Depression is particularly difficult to pinpoint in Afghan society, for neither Pushtu nor Persian 'contains easily understandable words that convey the meaning of psychic depression in a poorly educated population': Rafiq Waziri, 'Symptomatology of Depressive Illness in Afghanistan', American Journal of Psychiatry, vol.130, no.2, February 1973, pp.213-217, at p.214.

[21]Barnett Rubin, To Die in Afghanistan (1st ed., Helsinki Watch-Asia Watch, New York, December 1985) p.80.

[22]Bruno Bettelheim, Surviving and Other Essays (1st ed., Thames and Hudson, London, 1979) p.201.

[23]Fazel Haq Saikal, 'Health care problems in Afghanistan', The Medical Journal of Australia, vol.142, no.7, April 1, 1985, p.385.

[24]Dr Osman's testimony is set out in Michael Barry, 'Répression et guerre soviétiques', Les Temps Modernes, nos.408-409, July-August 1980, pp.171-234 at p.183, which cites the commandant's words in the original Dari: 'Serf yak mîlîyoûn nafar kâfîst ké dar Afghânestân zenda bâshad; mâ az yak mîlîyoûn Khalqi kâr dârîm, wa dîgar az hîtch kas kâr nadârîm, har kas ké bâshad, az bayn mîbarîm.'

[25]See Geoffrey Fairbairn, Revolutionary Guerilla Warfare: The Countryside Version (1st ed., Penguin, Harmondsworth, 1974) p.99.

[26]Jeri Laber and Barnett Rubin, 'Tears, Blood and Cries': Human Rights in Afghanistan Since the Invasion 1979-1984 (1st ed., Helsinki Watch, New York, December 1984) p.26.

[27] See M. Felix Ermacora, Rapport sur la situation des droits de l'homme en Afghanistan (E/CN.4/1985/21, Human Rights Commission, Economic and Social Council, United Nations, 19 February 1985) paras. 107-109.

[28]Grant M. Farr and Azam Gul, 'Afghan Agricultural Production: 1978-1982' Journal of South Asian and Middle Eastern Studies, vol.8, no.1, Fall 1984, pp.65-79, at p.67.

[29]Quoted in Jean-Pierre Turpin, 'L'enquête de quatre reporters', Défis afghans, no.4, August-October 1985, pp.4-5, at p.5.

[30]See Frances D'Souza, The Threat of Famine in Afghanistan (1st ed., AfghanAid, London, May 1984), and Soviet Analyst, vol.13, no.11, 30 May 1984, p.5.

[31]D'Souza, op.cit., Appendix II.

[32]On the merits of aid in cash as opposed to aid in kind, see the papers and conclusions from the conference 'L'Alimentation en economie de guerre: l'Afghanistan', Paris, 9-11 November 1984, Défis afghans, no.2, February-March 1985, pp.18-20.

[33]See Amartya Sen, Poverty and Famines (1st ed., Oxford University Press, Oxford, 1981), passim.

[34]On voluntary agencies, see Nancy Hatch Dupree, 'The VOLAG Explosion', The Afghanistan Forum, vol.13, no.6, November 1985, pp.25-28.

[35]Girardet, Afghanistan: The Soviet War, pp.215-223.

[36]Philippe Augoyard, La prison pour délit d'espoir: médicin en Afghanistan (1st ed., Flammarion, Paris, 1985)

[37]See the discussion cited in footnote 13.

[38]BBC Summary of World Broadcasts (FE/7956/C/1-2, 21 May 1985).

[39]House of Representatives Weekly Hansard, 29 November 1985, p.4078.

[40]See footnote 2.

[41]Girardet, 'The largest of all refugee operations', p.10.

[42]See Hasan-Askari Rizvi, 'Afghan Refugees in Pakistan: Influx, Humanitarian Assistance and Implications', Pakistan Horizon, vol.37, no.1, 1984, pp.40-61, at p.51.

[43]Girardet, 'The largest of all refugee operations', p.11.

[44]See Hanne Christensen, 'Food Situation', Refugees Magazine, no.2 January 1983, pp.14-16 at p.14, and Afghan Refugee Health Programme

Pakistan: Annual Report 1984 (1st ed., UNHCR and WHO, Islamabad, 1985) p.2.

[45]See William Maley, 'How we can aid Afghan refugees', The Age, 6 May 1985, p.13.

[46]Fazel Haq Saikal, 'Current Problems Facing Afghan Refugees', Al-Falah, vol.1, no.5, December 1985, p.2.

[47]Mohammad Najim Azadzoi, 'Settlements of Afghan Refugees in Pakistan: An Evaluation of Conditions and Identification of Problems', unpublished thesis for the degree of Master of Science in Architecture Studies, Massachusetts Institute of Technology, June 1984, p.28.

[48]Girardet, Afghanistan: The Soviet War, pp.208-209.

[49]UNHCR, Report on UNHCR Assistance Activities in 1983-1984 and Proposed Voluntary Funds Programmes and Budget for 1985 (UNHCR, A/AC.96/639, August 1, 1984) paras.1080-1084.

[50]Austrian Relief Committee for Afghan Refugees, Annual Report 1984, pp.4-5.

[51]Afghan Refugee Health Programme Pakistan: Annual Report 1984 (1st ed., UNHCR and WHO, Islamabad, 1985) p.8.

[52]Italian Cooperation for Development, Tuberculosis Control Program Among Afghan Refugees in N.W.F.P. Pakistan (ICD, Peshawar, December 1985) Part 3, Table 1.

[53]Afghan Refugee Health Programme Pakistan: Annual Report 1984 (1st ed., UNHCR and WHO, Islamabad, 1985) pp.9-10.

[54]Ibid., p.11.

[55]Austrian Relief Committee for Afghan Refugees, Annual Report 1984, p.17.

[56]Saikal, 'Current Problems Facing Afghan Refugees', p.2.

[57]Afghan Refugee Health Programme Pakistan: Annual Report 1984 (1st ed., UNHCR and WHO, Islamabad, 1985) p.12.

[58]Ibid., p.47.

[59]Ibid., pp.101-102.

[60]Joachim Bilger, 'Education', Refugees Magazine, no.2, January 1983, pp.30-31, at p.30.

[61]Étienne Gille, 'L'analphabétisme', L'Enseignement en Afghanistan (1st ed., AFRANE, Paris, October-November 1984) p.7.

[62]Bilger, op.cit., p.30.

[63]Alain-Pierre Lilot, 'L'enseignement dans les camps de réfugiés en Pakistan', L'Enseignement en Afghanistan (1st ed., AFRANE, Paris, October-November 1984) pp.22-24, at p.22.

[64]See J. Brau, 'A Peshawar ... école pour auxiliaires médicaux afghans', Les Nouvelles d'Afghanistan, no.26, December 1985, p.26.

[65]Afghan Refugee Health Programme Pakistan: Annual Report 1984 (1st ed., UNHCR and WHO, Islamabad, 1985) pp.28-29.

APPENDIX

The following organisations were consulted in the course of our research:

Afghan Information Centre
Austrian Relief Committee
Catholic Relief Service
Freedom Medicine
Harakati-Inquilabi-Islami Afghanistan
Hezbi-Islami Afghanistan
Institute of Policy Studies, Islamabad
International Committee of the Red Cross
International Medical Corps
International Rescue Committee
Italian Cooperation for Development (TB Control)
Jabheyi-Nejati-Melli Afghanistan
Jamiati-Islami Afghanistan
Kuwait Red Crescent
Mahazi-Melli Afghanistan
Medical Personnel Society
Medical Training for Afghanistan
Office of the Commissioner for Afghan Refugees
Salvation Army
Save the Children Fund
Saudi Red Crescent
Swedish Committee for Afghanistan
Union Aid for Afghan Refugees
Union of Afghan Mujahid Doctors
United Nations High Commissioner for Refugees
World Health Organisation

of a refugee population, and the conditions under which relief from public and private agencies can be delivered. Finally, non-medical factors determine the duration of a refugee problem. Health professionals must as a rule look to these factors when choosing between alternative schemes for the supply of aid, as the viability and utility of particular schemes may depend on such considerations. For this reason, it is necessary to establish the sociopolitical context within which solutions to public health problems must be devised. The first part of this paper is devoted to establishing this context for the benefit of those attempting to assist the Afghan refugees in Pakistan. It discusses in turn the historical events which produced the refugee flow, the societal characteristics which are reflected in the refugee population in Pakistan, and the political factors which determine the likely dimensions and future duration of the problem.

On April 27 1978, a coup d'état took place in Kabul, and brought to office a minute and bitterly factionalised pro-Soviet clique known as the People's Democratic Party of Afghanistan.[4] The coup had been triggered off by the mysterious assassination of a radical journalist, and those whom it brought to power were very poorly prepared for the tasks of running a government. They embarked upon a series of measures which, far from winning them support, in fact antagonised large sections of the population. The new regime promulgated one of the most ill-considered 'land reform' packages ever put forward in a Third World country - a package which entirely overlooked the crucial problems of rural seed and water supply, and the special needs of Afghanistan's pastoral nomads.[5] It also embarked on a 'literacy' campaign, actually so heavily laced with Marxism-Leninism that to a devout Muslim it was as odious as a slug of pink gin. Those who objected to its content were boorishly treated by those activists of the ruling party who had moved out into the

countryside to spread the Good Word. In addition, and perhaps most importantly of all, the regime took a number of steps which offended the religious sentiments of the population, in particular by changing the colour and motif of the national flag.

Furthermore, within three months of coming to power the regime had begun to collapse from within. Nearly all the senior members of the most loyally pro-Soviet Parcham ('Banner') faction of the governing party had been despatched abroad as Ambassadors, leaving the regime in the hands of Hafizullah Amin, the dominant personality in the Khalq ('Masses') faction. Amin and his nominal superior, President Nur Mohammad Taraki, travelled to Moscow in December 1978, and signed a Treaty of Friendship with the Government of the Soviet Union.

The regime's alliance with the Soviet Union did little to help it bolster its position. The anthropolgist Robert Canfield has detected amongst Afghans 'a special repugnance for the Soviets because of their avowed atheism, which to the Afghan moral conscience implies filthiness, gluttony, drunkenness and sexual promiscuity.'[6] In any case, the regime was soon confronted with spontaneous uprisings in different parts of the country, starting in the region of Nuristan but spreading rapidly. The regime moved with great savagery, but only little success, to put down these uprisings. In April 1979, government forces perpetrated in the village of Kerala in Kunar province an atrocity to compete with the dark name of Lidice: all the male inhabitants, over a thousand in number, were massacred in cold blood.[7] (Those widowed by this atrocity are now housed as refugees in a special village of the same name built for them by the Pakistan Government.[8]) Atrocities such as that in Kerala simply aggravated the situation. In June 1979, there was an uprising in the Hazara quarter of Kabul, as a result of which 300 Hazaras were trucked to a field outside Kabul, where half were doused

with petrol and set on fire, and the remainder buried alive with a bulldozer.[9]

The situation became so grave that the Soviet regime plotted with President Taraki to have Amin liquidated, but the plot miscarried and resulted instead in the removal of Taraki, who was strangled on Amin's instructions.[10] (When quizzed by foreign journalists about Taraki's cause of death, Amin is rumoured to have replied 'Don't ask me; I'm not a doctor'.) This effectively denied the USSR the opportunity to protect its client regime by reshaping it in a more attractive image, and left it with few options to prevent the overthrow of communist rule apart from military invasion. This option it exercised on December 27 1979, when circumstances seemed particularly propitious.[11] Almost the first move of the 85,000 man invasion force was to kill Amin, and replace him with Babrak Karmal, whose record as a loyal Soviet puppet was unimpeachable.

Even before the Soviet invasion, refugees had begun to flow into Pakistan - prompted by atrocities, or rumours of them, to quit their homes. By December 1979, there were 342,100 registered Afghan refugees in the North West Frontier Province of Pakistan. Within two years of the invasion, however, this figure had shot to 1.9 million.[12] The reason for this was that the Soviet invasion produced a qualitative change in the nature of the war within Afghanistan, increasing the sophistication of the weapons being turned on the Afghan population, and carrying the battlefronts to regions of the country which had not to that time been deeply involved in the conflict with the regime. In the years since the Soviet invasion, the regime in Kabul has had little or no success in consolidating its position, and even according to the then head of the Secret Police, Dr Najibullah, the regime in early 1985 controlled no more than 35% of the country[13] - in any case a considerable

exaggeration! However, with the use of MI-24 helicopter gunships, the USSR still manages to control the skies of Afghanistan, from which even the songbirds have now fled. The war in Afghanistan is continuing as fiercely as ever.

All this serves to explain how the refugee problem came about. However, in order properly to grasp the character of the refugee population, it is necessary also to have an understanding of the society from which they are drawn. Afghan society is exceedingly complex, featuring cleavages on ethnic, linguistic, cultural, geographical, and to an extent even religious lines. Ethnically, Afghanistan contains Pushtuns, Tajiks, Uzbeks, Turkomen, Hazaras, Nuristanis and representatives of many smaller groups. Linguistically, one can find Afghans who converse in Indo-European languages such as Pushtu, Baluchi and Dari, or Uralic-Altaic languages such as Uzbek or various Turkic dialects. Culturally one finds self identification in terms of religion, tribe, clan, and especially family; and values overwhelmingly determined by religious faith (as embodied in the Sharia, or Islamic law). Geographically, there is a marked distinction in character between the populations of rural and urban areas. Even in the sphere of religion, one must note certain distinctions between Sunni and Shia Muslims.[14] These cleavages appear to be of rapidly diminishing salience in the structuring of political attitudes, but they remain important to the aid worker, whose effectiveness may depend on a thorough grasp of the different attitudes, outside the political realm, which the members of the refugee population may hold.

It is important to note that these cleavages are cross-cutting. An Afghan may be, for example, at the same time a Sunni Muslim, a Pushtun, a Pushtu speaker, and a rural labourer or smallholder. For the health professional, all of these features may be in some way

significant, with different features being of primary importance at different times. A representative of the French organisation Médicins sans Frontières recently observed that the 'principal difficulty which we experience is that in Afghanistan we are entering another culture', and went on that 'to understand the symptoms by which the Afghans express their needs in the medical domain, it is necessary to penetrate their culture.'[15] Those who have sought to assist the refugees have not always penetrated as deep as one might hope (although there has been no reported repetition of the ludicrous episode of some years ago which saw a substantial shipment of sardines, briefcases, weight reducing powder, brassières and high-heeled shoes arrive in Pakistan for distribution as refugee relief [16]). An appraisal of the nature of the refugee population is therefore important if an aid programme is to be optimally structured.

The refugee population in Pakistan is a sample of the broader Afghan population, but it is not a random sample. Its composition is in part geographically determined. For many Afghans, flight to a neighbouring country may simply not be feasible, as the distance to be travelled may be so great that the chances of arriving alive appear slender. The hapless people in this position nonetheless may be obliged to quit their homes in order to avoid a premature despatch to a better world. Many of them have been forced to move to the cities of Afghanistan, swelling their populations and putting tremendous strains upon their facilities. The population of Kabul has more than doubled in the last eight years, increasing by 1985 to over two million.[17] The refugee population in Pakistan comes to a significant extent from the territory in the south and east of Afghanistan near the frontier, and thus contains a disproportionate number of ethnic Pushtuns, still in 1986 a majority, although the numbers from other groups are now increasing, for reasons which will be explained shortly.[18]

The composition of the refugee population also reflects the impact of the war. In October 1985, only 25.0% of registered Afghan refugees were adult males. 28.2% were women, and 46.8% children.[19] A large proportion of the adult males, however, are very old, and many of the women are in fact widows. It is thus little surprise that according to one recent study, based on field work conducted in refugee camps, 90% of the women refugees are suffering from depression.[20]

The war has also confronted Afghan society with the tragically novel problem of care for orphans. In the past, a child who lost his or her parents would be sheltered and reared by a male relative. However, an orphaned child now faces the distinct prospect of having no male relatives to perform this traditional duty. The Karmal regime has pounced on these young people. In 1981, it established an organisation known as the Foster Home of the Fatherland (Parwaresh gah-e watan). Except for its Head, who happens to be Babrak Karmal's wife, the staff is reported to consist entirely of Soviet citizens[21], who prepare the orphans on whom it can lay its hands for future use as party functionaries. However, many orphans are living in the refugee camps in Pakistan. They are deprived of the family support networks which traditionally have eased Afghan children into the turbulence of the adult world, and a number of perceptive Afghans are deeply worried about the values which the orphans will acquire from a life without hope and parental affection. At one level this is a political problem, as they may well drift into all-too-familiar patterns of nihilism. At another level, however, it is also a health problem, if by health we mean not simply physical health, but psychological health as well. 'The home environment', Bruno Bettelheim has argued, 'must generate hope for the future, if the child is to grow up to be a mentally healthy adult.'[22] These are the very things that the orphans presently lack.

The refugee population is in one sense, however, a microcosm of the larger group from which it is drawn: the refugees are victims not only of war related injuries and disabilities, but also of long-term health care problems which were apparent well before the Soviet invasion, and which spring from Afghanistan's great poverty. Three problems in particular stand out: (i) a shortage of trained personnel and equipment; (ii) a ubiquity of serious diseases; (iii) a population ill-prepared to make proper use of modern health care techniques.[23] Particularly worrying is the reappearance in the refugee camps of the practice of purdah, which in its strictest forms had fallen somewhat into desuetude in the small villages of Afghanistan, where the chances of a women encountering a man to whom she was not in some way related were not very great. This practice of purdah can be a severe obstacle to the implementation of health care programmes.

The above remarks, of course, only scrape the surface of what is a very complicated situation. This is partly because the situation is a fluid one, and the incremental additions to the refugee population - additions in the form of 1500 to 2000 new arrivals every week - not only add to the absolute numbers in Pakistan, but contribute to longer run changes in the character of the population. It is salutary to remember that the bulk of the Afghan population remains within Afghanistan, and that future developments may cause many of them to exit in further waves comparable to those of 1980-1981.

Dr Abdullah Osman, Professor of Psychiatry at Kabul University, was imprisoned in the Puli Charkhi concentration camp outside Kabul following the communist coup. He reported hearing the commandant of the camp, Sayid Abdullah, advance the following view: 'A million Afghans are all that should remain alive. We need a million communists. The others we don't need. We will get rid of them.'[24] This

view seems to inform the policies of the present regime, especially in rural areas. The political motive is quite clear. A principle of guerilla warfare which emerged from the Chinese Revolution was that the people are water, and the guerillas fish: without water the fish will die.[25] The Karmal regime is seeking to deprive the fish of water in which to swim, and is using bombardment and starvation to do it.

The bombing of rural areas has been the immediate cause of departure for a vast number of the refugees. 'Every time we asked an Afghan villager why he or she came to Pakistan,' wrote two researchers from the Helsinki Watch Committee, 'the answer began with the same two words: "shurawi bombard" ("Soviets bomb").'[26] Fragmentation bombs are a particular favourite of the Soviets, for the fragments of bomb casing which they disperse tend to create very nasty wounds which rapidly become infected. For military reasons, the Soviets prefer to cause lingering rather than quick deaths, as someone who is wounded will prove a greater burden to his or her fellows than someone killed outright - although gangrene of course kills a good many wounded before they have a chance to obtain medical treatment. It is for this reason also that the USSR has systematically scattered booby-trapped toys and anti-personnel mines in the Afghan countryside.[27]

The systematic destruction by bombing of Afghanistan's economic infrastructure has seriously affected the country's agricultural output. A recent detailed study concluded that agricultural production in 1982 stood at only 20% of its 1978 level.[28] Afghanistan is not experiencing a famine, but in particular areas there is considerable evidence of 'prefamine conditions' (which Dr Antoine Crouan of Médicins sans Frontières holds to exist when chronic malnutrition afflicts more than 10% of the population[29]). These prefamine conditions are a consequence not only of the absolute fall in agricultural output, but also

INTRODUCTION

This paper presents some preliminary findings from research conducted by the authors in the North West Frontier Province of Pakistan in January-February 1986. The research involved both interviews with officials of governmental and non-governmental international agencies, and with Afghan political and humanitarian bodies; and visits to camps housing both registered and unregistered Afghan refugees. The details are set out in the Appendix at the end of the paper.

Our aim is to identify the political context within which current problems facing Afghan refugees must be managed, and to highlight some of the more pressing difficulties of health care with which relief agencies must cope. The Office of the United Nations High Commissioner for Refugees, the World Health Organisation, UNICEF, and the World Food Programme are all actively involved in providing basic sustenance for the refugees, but the sheer size of the refugee population continually threatens to thwart their efforts.

The war in Afghanistan has now lasted for longer than the Second World War, and the sufferings of the Afghan people have been as dreadful as those of the victims of Nazism. In 1946, Churchill pointed out that by inattention to the Nazis' crimes against the weak, even the strong had been 'sucked into the awful whirlpool'. With the horrifying example before us of what has occurred in Afghanistan, we should never send to know for whom the bell tolls.

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Afghan Refugee Relief in Pakistan: Political Context and Practical Problems

by

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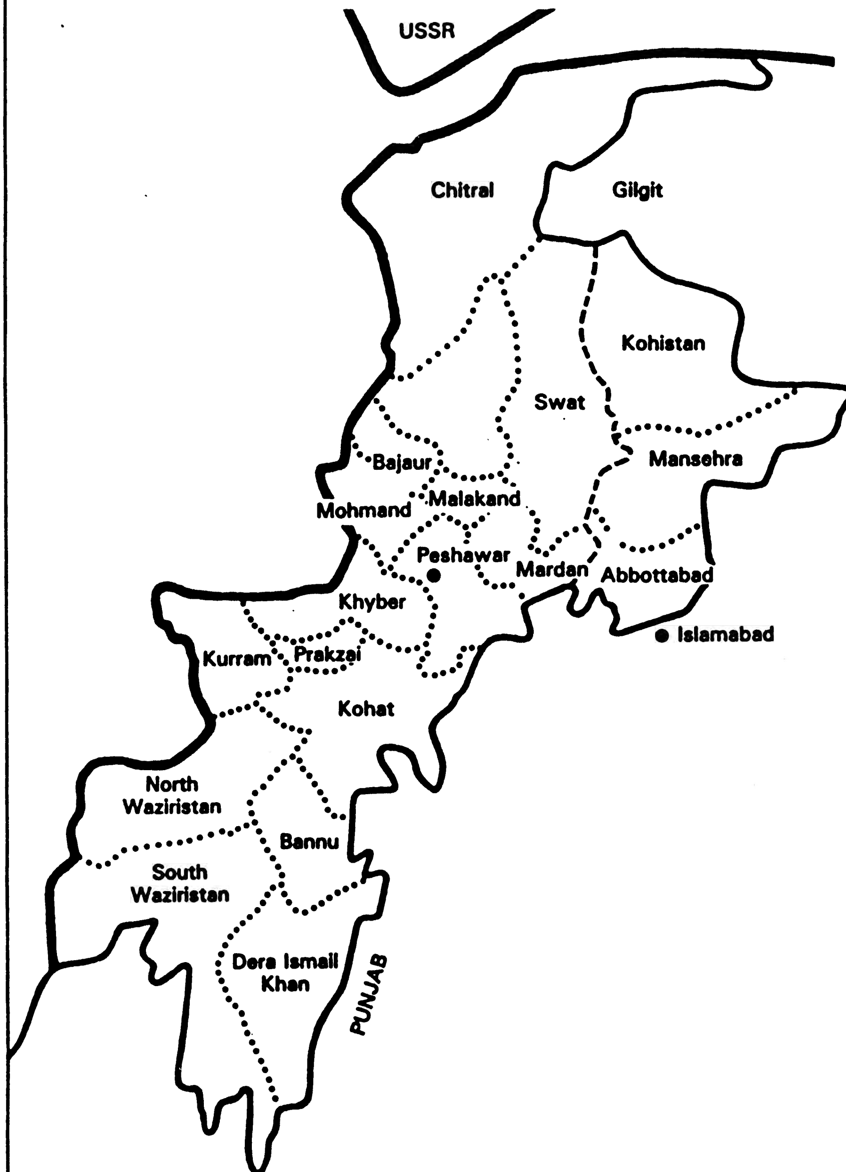
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To the suffering people of Afghanistan



USSR
CHINA
IRAN
Jammu
and
Kashmir
AFGHANISTAN
PAKISTAN
INDIA
Mary
Dushanbe
Termez
Amu Darya
Kunduz
Faizabad
Sheberghan
Mazar-i-Sharif
Taluqan
Samangan
Baghlan Jadid
Maimana
Torgondi
Qalai Naw
Islam Qata
Herat
Charikar
Kabul
Peshawar
ISLAMABAD
Cease Fire Line
Indus
Ghazni
Kalat
Lashkergah
Qandahar
Spin Baldak
Quetta
Helmand
KUNDUZ
JOZJAN
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BALKH
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BADGHIS
KUNAR
BAMIYAN
LAGHMAN
KAPISA
PARWAN
GHOR
WARDAK
KABUL
NANGARHAR
HERAT
LOWGAR
UROZGAN
PAKHTIA
GHAZNI
FARAH
PAKTIKA
ZABUL
KANDAHAR
NIMROZ
HELMAND
AFGHANISTAN
International boundaries
Kashmir district boundary
Prov/Admin boundaries
Major roads
Railways
Rivers
0 50 100 150 200 250 Kms
0 50 100 150 Mls
Source: Afghan Information Centre, Peshawar



NORTH-WEST FRONTIER PROVINCE
USSR
Chitral
Gilgit
Kohistan
Swat
Mansehra
Bajaur
Malakand
Mohmand
Peshawar
Mardan
Abbottabad
Khyber
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Kurram
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South
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